

Opioid and/or Opioid-Benzodiazepine Combination

Member and Medication Information (required)		
Member ID:	Member Name:	
DOB:	Weight:	
Medication Name/ Strength:	Dose:	
Directions for use:		
Provider Information (required)		
Name:	NPI:	Specialty:
Contact Person:	Office Phone:	Office Fax:
FAX FORM AND RELEVANT DOCUMENTATION INCLUDING: LABORATORY RESULTS, CHART NOTES and/or UPDATED LETTER OF MEDICAL NECESSITY TO 855-828-4992		

Non-Preferred Opioids:

- 1) Trial and failure of at least one preferred agent in the drug class.
Medication used: _____ Chart Note Page #: _____
Details of failure (including duration): _____
- 2) Clinical rationale of possible drug interaction or contraindication that prevents use of the preferred drug: _____
_____ Chart Note Page #: _____

Short-Acting Opioids: *Prior Authorization may not be required if member has filled initial script of the same medication for a 7-day supply or 3-day for dental providers.*

- 1) Clinical rationale for member not receiving initial fill: _____
_____ Chart Note Page #: _____
- 2) Clinical rationale for exceeding Utah Medicaid Quantity Limit or MME limit of 90 MME/day: _____
_____ Chart Note Page #: _____

Long-Acting Opioids: *Prior Authorization may not be required if member has filled short acting opioid within 30 days of initiating therapy on a long acting opioid.*

- 1) Clinical rationale if member is younger than 18: _____
_____ Chart Note Page #: _____
- 2) Clinical rationale if member is pregnant: _____
_____ Chart Note Page #: _____
- 3) Clinical rationale if member has not received short acting opioid in past 30 days: _____
_____ Chart Note Page #: _____
- 4) Clinical rationale for exceeding CDC recommended limit of 90 MME/day: _____
_____ Chart Note Page #: _____
- 5) Non-opioid pain medication history. Member is using or has tried and failed at least two of the following: NSAIDs, non-opioid analgesics, antidepressants, or anticonvulsants.
Medication used: _____ Chart Note Page #: _____
Details of failure (including duration): _____
Medication used: _____ Chart Note Page #: _____
Details of failure (including duration): _____

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

Opioid and Benzodiazepine Combination: **FDA Black Box Warning**

1) Clinical rationale and diagnosis for member receiving benzodiazepine and opioid within last 45 days: _____
_____ Chart Note Page #: _____

2) Most recent opioid prescription information:
Medication Name and Strength: _____ Quantity/Day Supply: _____ Date Prescribed: _____

3) Most recent benzodiazepine prescription information:
Medication Name and Strength: _____ Quantity/Day Supply: _____ Date Prescribed: _____

Opioid Use Disorder (OUD): Clinical rationale for opioid request if member received Medication Assisted Treatment (MAT), such as Suboxone, within the last 45 days: _____
_____ Chart Note Page #: _____

Opioid Tapering Plan: *Provider must discuss possible reduction in dose, tapering and discontinuation with member.*

Details of taper plan or rationale for the lack thereof: _____
_____ Chart Note Page #: _____

Provider attests to all of the following:

- ☐ Provider has a signed opioid treatment agreement with the member.
- ☐ Provider has checked the Utah's Controlled Substance Database with each prescription.
- ☐ Provider has discussed with the member benefits and potential harm, including combining opioids with other CNS depressants.
- ☐ Provider has counseled members with high-risk conditions (sleep apnea, pregnancy, mental health conditions, substance abuse disorders, or children) about the heightened risk of using opioids.
- ☐ Member has received naloxone education.

Initial authorization: Up to three (3) months

Re-authorization: Up to six (6) months

Authorization for use with MAT: Up to fourteen (14) days, no re-authorization

PROVIDER CERTIFICATION

I certify that the information provided on this form is true and accurate to the best of my knowledge.

Prescriber's Signature

Date